Correspondence

The Editorial Board will be pleased to receive and consider for publication correspondence containing information of interest to physicians or commenting on issues of the day. Letters ordinarily should not exceed 600 words, and must be typewritten, double-spaced and submitted in duplicate (the original typescript and one copy). Authors will be given an opportunity to review any substantial editing or abridgement before publication.

Of *Giardia* Cysts and Sportsmen

TO THE EDITOR: *Giardia* cysts in drinking water are a widely-recognized hazard to sportsmen, and as Jarroll and co-workers[1,2] have shown, the common methods of chemical disinfection cannot be relied upon to kill the cysts in cold water. Boiling is the suggested alternative. While this is effective, hikers are reluctant to use any method which would greatly increase the burden of fuel to be carried. Indeed, many people will continue to use chemicals for this reason, in spite of the hazard.

A simple compromise is to slightly raise the temperature of the water to be treated; at 20°C, all the chemical methods tested by Jarroll and his co-workers were found to be completely effective. By bringing one fifth of the total volume of water to a boil, and mixing the hot and cold portions, a minimum temperature of 20°C will be reached with even the coldest stream water (allowance must be made for high altitudes). Chemical treatment is then carried out. Fuel expenditure is dramatically reduced, and no thermometer or large cooking vessel is necessary.

BRIAN MOONEY, BA
Montpelier, Vermont

REFERENCES

1. Jarroll EL Jr, Bingham AK, Meyer EA: *Giardia* cyst destruction: Effectiveness of six small-quantity water disinfection methods. Am Trop Med Hyg 1980 Jan; 29:8-11
2. Jarroll EL Jr, Bingham AK, Meyer EA: Inability of an iodination method to destroy completely *Giardia* cysts in cold water (Information). West J Med 1980 Jun; 132:567-569

The Devil of Nutrition Cultism

TO THE EDITOR: The publication of humorous and whimsical letters often brightens the days and late evenings of physicians who often carry numerous burdens.

It was with the presumption of a framework of whimsy that I approached the letter by John M. Douglass, MD, and others[1] in the February 1982 issue.

However, about a third of the way through, I realized I was not reading humor but either a foreign language or a set of thought processes so foreign to logic and science that it was unrecognizable as modern American medicine or modern American English.

I therefore wish to take to task the editorial staff for publishing letters written in foreign languages or in extraterrestrial logic forms without adequate translation or editoral comment.

I thank you for giving greater attention to this matter in the future.

WALLACE I. SAMPSON, MD
Mountain View, California

EDITOR'S NOTE: Thank *you* for your editorial comment!
—MSMW

REFERENCE

1. Douglass JM, Douglass RN, Fleiss PM: The first devil of nutrition cultism (Correspondence). West J Med 1982 Feb; 136: 167-168

Beeper Bite: A Jogging Complication in Physicians

TO THE EDITOR: Immediately following a seven-mile run, a 34-year-old physician marathoner noted the presence of a 2- by 2-cm excoriated erythematous patch of skin overlying the right iliac crest. He had run with a pager (Motorola, Pageboy II) clipped to his jogging shorts, immediately overlying the site of the skin lesion. His shirtless garb put the metal clip (chromium plated aluminum) of the pager in direct contact with skin. The following day the physician ran with the pager clipped on the left side, yielding a similar eruption overlying the left iliac crest. The differential diagnosis consisted of contact dermatitis versus abrasions. The inert nature of the metallic clip and general appearance of the rash led to a diagnosis of beeper clip abrasions. Jogging continued *sans* beeper and the eruption cleared promptly.

Other therapeutic modalities may be helpful if a physician refuses to jog without beeper. Protective padding might be sewn into the shorts or strapped over the beeper with a rubber band. A shirt tucked into the shorts might help. An alternative would be to encourage the physician to

hand carry the beeper while jogging. To our knowledge, this complication of jogging has not previously been reported, but we suspect it is not an uncommon occurrence in obsessive/compulsive physician-joggers who cannot part with their beepers.

Beeper bite raises problems of morals and medical ethics. Why carry a beeper at all unless telephones are handy? Is it appropriate to ask another physician to take calls for an hour or so of jogging time, every day? Since one of the reasons for jogging is to "get away from it all" for a brief time each day, is not the act of carrying a beeper inconsistent with this goal? These issues should be carefully considered by a physician involved in a regular jogging program.

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Family Medicine for Primary Care

TO THE EDITOR: I would like to agree with Dr. Geyman's editorial comments regarding Dr. Kurtz's January article on primary care.[1,2] Dr. Kurtz has a misunderstanding of the need for family medicine as a specialty. Primary care internal medicine or pediatrics is not an acceptable alternative to family medicine.

I have lived most of my life in the rural areas of Idaho and Wyoming, and am familiar with the rural areas of Nevada and Southwestern Montana. I have received only praise from those people who live in the rural areas for choosing family medicine as my specialty.

Why? The answer is always the same: "Because we want a family doctor!" They do not want to be shifted from an internist to a pediatrician to an obstetrician or from a child health associate to a physician's assistant or a nurse practitioner to a nurse midwife. They want centralized, continuous care for themselves and their children from a family doctor, especially one who does obstetrics.

The need for family physicians is as great as the need for other specialists. Family physicians are in demand. They are cost effective, and the new family physicians are well trained.

Primary care training already exists in the excellent specialty of family medicine. There is no need for such a subspecialty in internal medicine or pediatrics. What is needed is continued growth and cooperation among the disciplines of family medicine, internal medicine, pediatrics, surgery, and obstetrics and gynecology so that quality training is available.

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Denver

REFERENCES

1. Kurtz KJ: Training the internist for primary care: A view from Nevada (Medical Education). West J Med 1982 Jan; 136: 76-82
2. Geyman JP: Training for primary care: A family practice perspective (Medical Education: Editorial Comment). West J Med 1982 Jan; 136:83-84

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TO THE EDITOR: Dr. Kenneth Kurtz subtitles his recent article on primary care training[1] as "A View From Nevada." I wonder if he intended to represent Tonopah, Elko or even the communities of metropolitan Reno. From reading his article, it is apparent that his views emanate from a department of internal medicine at a university medical center.

Dr. Kurtz conceptualizes a model where nurse practitioners would possibly manage problems that require limited medical knowledge "in each sector of the family practice sphere," with single discipline specialists such as a primary care internist with five years of postgraduate training providing the rest. Do most people want or need a team that combines two extremes?

Dr. Kurtz indicates that "family practice physicians are caught in the intense squeeze of modern biomedicine." As a recent family practice residency graduate now in practice, I have not felt squeezed nor have I noticed this among my colleagues. The joy of entering practice after a family practice residency is the realization of being very well trained to manage the great majority of people's health problems. I wonder if Dr. Kurtz has stepped beyond the clinics of academia to experience this.

Dr. Kurtz also states that because of the breadth of family practice training, the result is "often a very broad, but necessarily superficial, knowledge of many aspects of medicine." I will readily admit a superficial knowledge of cryoglobulins, renal tubular acidosis, and Wegener's granulomatosis. However, along with an in-depth knowledge of the persons and families who are my patients, I know ambulatory diabetes, hypertension, obesity, degenerative arthritis, congestive heart failure, and so forth, as well as a good primary care internist.

It is unfortunate that so many internists and others in the academic setting do not accept